Your Guide To Medicaid

West Virginia Department of Health and Human Resources

Introduction

The information which follows tells you what services are paid for by your Medical Card, what your rights and responsibilities are under the Medicaid Program, and how and where you may receive additional information.

Please keep this information booklet available to refer to as you have questions. If you need more detailed information, you may call the phone numbers listed in this booklet.

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Medical Services Covered by Medicaid

- Physician's services.
- Hospital inpatient care.
- Outpatient hospital services.
- Emergency room services.
- X-ray and laboratory services prescribed by an authorized practitioner.
- Routine dental care for children and with approval some medically necessary special care such as braces. Adult dental coverage is limited to removal of cysts or tumors, biopsies, treatment of fractures of the jaw bones and some emergency services.
- Prescribed drugs. Most of the drugs that are prescribed by your doctor are covered by the Medicaid Program. Drugs sold over-the-counter must be prescribed by your doctor to be covered. Some drugs have limits and some may require prior approval.

  The Medicaid Pharmacy Program does have a Preferred Drug List (PDL). Your doctor and pharmacist have copies of this list. If the drug that is prescribed for you is not on the list, a prior approval will be required. In most cases, the drug prescribed or a substitute (approved by your doctor) from the list, can be given to you while you are in the pharmacy. If not, a three-day emergency supply of your prescription is always available to you. You should never leave the pharmacy without some of your medicine. As soon as the approval is given, you will be able to get the rest of your prescription.

  You should show your Medicaid card to your pharmacist each time you have a prescription filled. You will be asked to pay a co-pay for each prescription. Children and pregnant women do not have to make this co-payment. It is best to have all of your prescriptions filled at the same pharmacy. By doing this, your pharmacist and doctors can make sure that your prescriptions work together for you.
- Transportation to medical facilities by ambulance or other most appropriate means.

- Artificial limbs, braces, orthopedic shoes, crutches, walkers, wheelchairs and breathing machines, when prescribed by a doctor.

- Eye care services. Comprehensive vision care services are covered for children through age 20. Adult coverage is limited to one pair of eyeglasses following cataract surgery.

- Care in nursing facilities.

- Family planning services.

- Outpatient mental health services.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children aged 0-20 years.

This does **not** include all medical services you can receive through the Medicaid Program. Some types of medical care you may need will require prior approval from the West Virginia Department of Health and Human Resources.

Note: The West Virginia Department of Health and Human Resources does place certain limitations on the extent of services that can be provided and the fees that will be paid.

Persons eligible for the Medicaid Program obtain medical services by presenting their cards to participating physicians, hospitals, pharmacies or other providers of medical services. The medical service provider then bills the West Virginia Department of Health and Human Resources for payment.

Out-Of-State Medicaid Coverage

Only the following types of medical services received outside the State of West Virginia are covered under the Medicaid Program:

1. Emergency treatment that is received while traveling or visiting out of state, or

2. Treatment received after prior approval from WV DHHR.

   The referring physician must request prior approval.

Out-of-state services are usually not approved if they are available in West Virginia.

All out-of-state providers will have their claims denied for non-emergency medical services unless:

1. They have been declared a border provider.

   Certain medical providers practicing within 30 miles of West Virginia have been granted "border status." These medical providers are considered in-state providers and do not have to obtain prior approval for services except in those instances where it is required of in-state providers.

2. The services have been prior approved.

If you move from the State of West Virginia, go to that state's nearest Health and Human Resources office and ask to apply for Medicaid. West Virginia's Medicaid Program pays only for people who live in West Virginia.

Non-Emergency Medical Transportation Program (NEMT)

The Non-Emergency Medical Transportation Program, or NEMT, consists of cash payments made to Medicaid members or vendors on behalf of eligible members who need transportation to a medical facility.

Mileage is reimbursed when private automobiles are used. A small meal allowance is available for when overnight lodging is required. Transportation may also be available via common carrier when travel by private automobile is not available.

In order to be eligible for NEMT, a person must be a Medicaid member and:

1. Have an appointment for any medical treatment that is approved under Medicaid guidelines, and

2. Receive prior approval from the West Virginia Department of Health and Human Resources before the trip is made.

For more information, contact your local office of the West Virginia Department of Health and Human Resources.

How To Apply For Medicaid

If You Receive Supplemental Security Income (SSI)

If you are receiving a check from Supplemental Security Income Program, you are automatically eligible for Medicaid and should receive a medical card from the West Virginia Department of Health and Human Resources.

If You DO NOT Receive SSI

If you are not receiving an SSI check, you must apply for Medicaid benefits.

Applications are taken weekdays at your local office of the West Virginia Department of Health and Human Resources. For your convenience, you may wish to call for an appointment.

Most local hospitals and primary care clinics have staff available to assist you in making application.

If, because of a physical handicap or disability, you are unable to go to the local office, you may request a staff person to visit your home and take the application. To request a home visit, call your local office of the West Virginia Department of Health and Human Resources or call the Office of Client Services toll free at 1-800-642-8589.

PROVIDING DOCUMENTATION OF CITIZENSHIP FOR MEDICAID CITIZENSHIP AND IDENTITY REQUIREMENTS

Prior to the enactment of the Deficit Reduction Act (DRA) of 2005 on February 8, 2006, if you had Medicaid or applied for Medicaid, you could declare your citizenship and identity status through self-attestation.

Congress passed a new law. Beginning on July 1, 2006, all people who are recipients of Medicaid or people who are applying for Medicaid must be able to document that they are U.S. citizens or nationals. If you are enrolled in Medicare or receive SSI you will not be affected by these new provisions or requirements. Also, this provision does not affect individuals who have declared they are aliens in a satisfactory immigration status.

Section 6036 of the DRA requires evidence of both citizenship and identity and specifies forms of acceptable evidence of citizenship or nationality and identity.

To establish U.S. citizenship the document must show:
- A U.S. place of birth, or
- That the person is a U.S. citizen.

To establish identity a document must show:
- Evidence that provides identifying information that relates to the person named on the document.

The best way to document that you are a citizen is with one of these:
- A U.S. Passport
- A Certificate of Naturalization (DHS Forms N-550 or N-570)
- A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)

If you do not have any of these documents, you will need two documents, one to show you are a citizen and one to show who you are.

Document you are a citizen with:
- Your birth certificate, or

- A Report of Certification of Birth Abroad of a U.S. Citizen (Form FS-240 or FS-545), or
- Adoption Papers, or
- Military record.

Document your identity with:
- Your picture on your current State driver's license or State identity card, or
- School identification card, or
- A Federal, Sate or Local government identification card, or
- A U.S. Military identification card.

All applicants and recipients must be given a reasonable opportunity to provide documents to establish U.S. citizenship or nationality and identity. Current recipients continue to receive benefits until determined ineligible. Medicaid is closed only after the recipient is given a reasonable opportunity to present evidence or fails to make a good faith effort to provide it. Applicants are not approved until the required verification is supplied.

For assistance, contact your local DHHR office of call 1-800-642-8589.

Determining Eligibility for Medicaid

Except in the case of pregnant women and children up to age 19 years, eligibility for Medicaid is based on categorical relatedness, income and assets.

Categorical relatedness means that an applicant must be a member of a family with a child who is deprived of support due to the absence, incapacity or unemployment of a parent(s). If the applicant has no children under age 18, the individual must be age 65 or over, blind or disabled.

The second factor considered is an applicant's income and assets. Income is any money a family or individual receives such as wages, pensions, retirement benefits or support payments. Assets include money in the bank, property other than the homestead, and the cash or loan value of certain life insurance.

When applying for Medicaid, you will be asked about your income and assets you own. DHHR staff will inform you of any documentation needed at the time of your application.

The eligibility of pregnant women and children up to age 19 for Medicaid is determined solely on income. There is no asset test. Pregnant women must provide a medical statement confirming pregnancy.

What is "Spenddown"?

Individuals and families who are INELIGIBLE for medical assistance (Medicaid) at the time of application because of income higher than the "protected level" may become eligible under the "spenddown" process.

The process of subtracting your medical bills from your family income in order to become eligible for Medicaid is called "spenddown." The month of application, plus five months, equals a period of spenddown consideration. You may use current payments OR the unpaid balance on "old" medical bills in order to meet spenddown and achieve eligibility at the earliest possible time.

However, if you choose to use old bills to meet your spenddown, you may not use them again for the same purpose.

Your Medical Card

If you qualify for Medicaid, you will receive a medical card. Persons or families already receiving an assistance check from the West Virginia Department of Health and Human Resources or the Supplemental Security Income Program (SSI) will automatically receive a medical card each month on or about the first day of the month.

Your medical card shows that you have Medicaid benefits. For this reason, you should carry it with you at all times, being careful not to lose it or to let anyone else use it.

Your Medicaid card shows a definite period of eligibility for named individuals. You will receive a new medical card each month as long as you are eligible.

If you are a member of an HMO, you will also receive an insurance card from them. You will need to show both cards to the providers when receiving medical care.

Be sure to carry your most recent card and present it to the medical provider each time you need medical care. The provider will usually make a copy of the card. **It is against the law to let anyone else use your card.**

If you should lose your medical card, notify your local office of the West Virginia Department of Health and Human Resources immediately. Tell them if you are in managed care.

Other Coverage Cards

If you also have a managed care, insurance or red, white and blue Medicare Card, present these cards when requesting medical services along with your Medicaid card.

Charges for services provided to individuals with HMO, insurance or Medicare coverage must be billed to those payers first. Individuals in PAAS have special rules for providers other than their regular doctor or clinic.

Other Medical Insurance

Federal regulations mandate that states identify any third party resource available to meet the medical expenses of a member. This third party may be an individual, institution, corporation or public or private agency that is liable to pay all or part of the medical costs of the member.

Therefore, if you have medical insurance, veterans' coverage, Medicare or any other medical coverage, including court or insurance settlements, they should pay for your care before Medicaid. In order for Medicaid to pay as secondary, you must follow the plan provisions of your primary insurance, which includes using your plan network of doctors, dentists, facilities, pharmacies and other providers of medical services designated by your plan. You must also follow all pre-certification requirements of your plan. If you receive money from insurance or law suit claims for medical care, you must use it to pay the provider. If there is a delay and Medicaid pays for a service covered by your insurance, or paid from a law suit, a refund must be made to Medicaid. When your insurance is not enough to pay your medical bills, Medicaid may be able to help.

Having other insurance coverage does not affect your eligibility for Medicaid. If your provider accepts your other insurance and your Medicaid card, you cannot be billed for the deductible or co-insurance. The provider will bill Medicaid as your secondary insurance. If you have access to health insurance through your employer, you may be eligible for the HIPP (Health Insurance Premium Payment) Program. This program may pay your insurance premium for you as long as you or a family member are eligible for Medicaid.

Your Responsibilities

Changes Affecting Eligibility:

As a participant in the Medicaid Program, you have a responsibility to immediately notify the West Virginia Department of Health and Human Resources of any change in circumstances which may affect your eligibility, such as an address change, an increase in income or assets, a change in family members or receipt of insurance, Workers' Compensation, Social Security retroactive settlement or any other type of settlement. Failure to report such changes may constitute fraud. A person is subject to prosecution whenever he/she willfully presents false statements, misrepresentations, impersonations or other fraudulent devices, and/or obtains or attempts to obtain, or aids and abets any person in obtaining medical assistance to which he/she is not entitled.

Keeping Appointments:

You have a responsibility to keep all appointments with doctors, dentists, clinics, laboratories and other providers of medical services. If you are unable to keep your appointment, please notify them immediately.

Do Not Pay for Covered Medical Services:

You should not pay for **covered** medical services you receive. **If you do, there is no way for you to get your money back.** The provider of the service must bill the West Virginia Department of Health and Human Resources and payment must be made directly to the provider.

If you sign an agreement with a provider to pay for services that are not covered by Medicaid or seek services not covered by your managed care plan, then you must pay for these services.

Your Rights

Discrimination Prohibited:

Medicaid benefits will be extended in full compliance with the 1964 Civil Rights Act which prohibits discriminatory administration of benefits from federally funded programs because of sex, race, color, religion, national origin, ancestry, age, political affiliation or handicap.

Confidentiality:

Any information obtained from you or concerning you shall be kept confidential. No information regarding applicants or members shall be disclosed for any purpose other than those directly concerned with administrative requirements. A copy of the Medicaid Notice of Privacy Practices is at the end of this booklet.

Right To Appeal:

You have the right to appeal if you are not satisfied with the decision regarding your application and/or it is not handled within a reasonable period of time; if you were not allowed to file an application; or if you think you were treated unfairly in any way. Requests for appeals should be directed to your local office of the West Virginia Department of Health and Human Resources.

If you have received notice of a reduction, suspension or termination of a Medicaid covered service, you have a right to appeal that denial or termination through the fair hearing process. The notice that you receive will include an explanation of your appeal rights and a form that you may use to request a fair hearing.

You may represent yourself or use legal counsel, a relative, friend or other spokesperson.

If you appeal prior to the date of termination of a covered service, you may continue the service. However, if the state's action is upheld, the agency may start recovery actions to recoup the cost of the services furnished.

Denial of Payment for Services:

There are certain reasons why the West Virginia Department of Health and Human Resources may deny payment for your medical bills or prescription drugs:

1. Your doctor may not have asked for special permission (prior approval) from the Department in order to get certain services paid.

2. Certain services are not covered by the West Virginia Medicaid Program.

3. You may have gone beyond the limits of coverage.

4. You may not have been entitled to a Medicaid card on the date of services.

5. Your doctor may not have filled out the forms properly, or may not have been a Medicaid provider when the service was rendered.

Managed Care Programs HMO and PAAS

Managed care is a health system in which a group of health care providers have agreed to coordinate and provide health care. This program is provided to those who are eligible and, in some cases, those who choose to enroll. In most cases, children, pregnant women and families with children are required to enroll in managed care. If you live in a nursing home, long-term care home, children's home, or a treatment facility, you will not be eligible for managed care.

Depending on the county in which you live, you will be asked to choose either a Physician Assured Access System (PAAS) Primary Care Provider (PCP) or a Health Maintenance Organization (HMO). You will receive directions in the mail on how to do this. If you do not understand, please call 1-800-449-8466.

You may change your PCP or HMO by calling 1-800-449-8466. They have lists of HMOs and PCPs who are managed care providers in each county.

The HMOs and the PAAS Program can help you if you have a complaint. You can reach them by calling 1-800-449-8466. You also have a right to a fair hearing as described in the section "Your Rights" of this manual.

The PAAS Program

The Physician Assured Access System (PAAS) is a group of providers who will provide or approve most of your health care needs. You will be asked to choose a Primary Care Provider (PCP). The PCP is your medical home.

Before you see a specialist, please contact your PCP. Your PCP must give you a referral. You may make your own appointments. You may make your own appointments for family planning, some vision, hearing and dental services, obstetrical/gynecological and behavioral health services.

Doctors in the PAAS Program have agreed to provide access to 24-hour care. If you have a true emergency, go to the nearest emergency care center. You do not need approval from your PCP for an emergency.

Mountain Health Trust Program - Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) is a group of health care professionals - doctors, clinics and hospitals - that will provide most of your health care needs. If you are asked to choose an HMO, you will also be asked to pick a PCP who will handle most of your medical needs. The PCP becomes your medical home.

If you need to see a specialist or you need hospital care, your PCP will set that up for you.

For behavioral health, pharmacy, long-term care, dental, and non-emergency transportation, you will need to show your medical card when getting care. You may ask the local DHHR for help with travel to medical appointments. **Always give the provider both your medical card and your HMO card when getting services.**

If you have questions or would like more information call 1-800-449-8466

Notice to all Medicaid Managed Care Consumers

If you have Medicaid health insurance and you belong to an HMO or PAAS, you have the right to request the following at least once a year by calling 1-800-449-8466:

- A directory of all current contracted providers
    - Names/addresses/telephone numbers
    - Languages other than English
    - Closed or open practice
    - Primary care/specialist/hospital
- Instructions on how to use the directory
    - Your choice of provider
    - Referral process for specialty care
    - Explanation of network
- Information on grievance and fair hearing procedures and the time frame
- Services which continue to be accessed under fee-for-service
    - Some family planning services
    - Pharmacy
    - Children's dental
    - Non-emergency medical transportation
    - Behavioral health
    - Long Term Care/Nursing Homes
- Your Rights and Responsibilities
- Emergency services
    - If you have an emergency go to the nearest emergency center or call 911
    - Prior authorization is not required for emergencies
- Benefits
    - Procedures for obtaining
    - Those not covered
    - After hours access

- Advance Directives or a “living will” allows someone else to make medical decisions for you if you are unable to make your own decisions.
- How doctors are paid

MOUNTAIN HEALTH CHOICES

Mountain Health Choices is West Virginia's new Medicaid program for poverty level children and their parents who are not disabled.

If you already receive Medicaid, you will receive in the mail a packet from Automated Health Systems/Mountain Health Choices 60 days before your eligibility re-determination date.

If you are a new applicant, you will receive a packet from Automated Health Systems/Mountain Health Choices.

In both cases, the packet will contain information about the benefit plans, the member agreement and the health improvement plan. It is important not to throw this information away.

Basic and Enhanced Plans

If you do nothing with the packet you receive in the mail, you will have the basic benefit plan. You will have the chance to move to the enhanced plan when you receive the packet. You will have 90 days after the eligibility determination date in which you can switch to the enhanced plan.

Member Agreement

You will be asked to follow the rules of the program. You will be asked to do your best to stay healthy, which may mean taking special classes or trying to quit smoking or lose weight. You will be expected to use the medical home for you and your children, to keep your appointments, take medicine as prescribed and read materials you are given. You will be expected to contact the medical home if you can't keep appointments. You will also be asked to agree to use hospital emergency rooms only for true emergencies.

What rights do I have under the Member Agreement?

According to the member agreement, you have the right to pick your medical home and make decisions about health care for you and your children. You have the right to see your medical records and ask questions about health care. You have the right to be treated fairly and with respect, to know the laws and rules of the Medicaid program, and ask questions about the plan. You will be notified in writing if any care is denied or limited, and you have the right to appeal a decision that denies or limits services and request a fair hearing.

What is a Health Improvement Plan?
A health improvement plan is something you may be asked to agree to with our health care provider about steps to take in the coming year to improve your health or the health of your children. It may involve agreeing on a certain number of checkups, tests or screenings or keeping up with vaccinations. It may also include attending classes designed to improve health or trying to quit smoking or lose weight. This should be a joint plan between you and your doctor. It's important to try to reach agreement on a plan that is realistic for you and that you are committed to keep. **You are not required to sign a health improvement plan to receive enhanced benefits.**

When do I have to sign a member agreement?
If you already receive Medicaid, the member agreement must be turned in within 90 days of your re-determination date for you and your children to receive enhanced benefits. If you are a new applicant, you must do so within 90 days of the application date.

Differences between the Basic plan and the Enhanced plan
There are big differences between the basic and enhanced plan for both adults and children. **You and your family will have more covered benefits with the enhanced plan than you will with the basic plan.**

How to sign up for the Enhanced plan

1. When you receive your first or next packet from Automated Health Services about Mountain Health Choices, choose a primary care provider, which becomes your medical home. Make an appointment as soon as possible with a health care provider from your medical home. Try to schedule your appointment in the first half of the month.
2. With health care providers at your medical home, read and sign a member agreement and develop a health improvement plan if you and your physician determine that one is needed.
3. Be sure the agreement and plan are returned to Automated Health Services within 90 days of receiving your packet. Get a copy of both documents from your medical home and keep for your records.
4. The medical home must fax this to Automated Health Services at 1-866-463-5782 within 90 days from your eligibility determination date. Check with your medical home and Automated Health Services to make sure it has been done.

KEY TERMS TO KNOW

Basic plan: A health coverage plan that does not include several new extra features and may limit the services available.

Enhanced plan: A health coverage plan that offers extra services, coverage and classes.

Health Improvement Plan: A plan you agree to with your medical home which outlines steps you and your children will take in the coming year to improve health.

Medical home: Your central source of health care where you will see a doctor and where your medical records are kept and all your care will be coordinated.

Member Agreement: An agreement you must sign in which you agree to certain responsibilities and which promises you rights.

Forms and plan descriptions are attached to this guide. You can also find forms, benefit plans and additional information about Mountain Health Choices at: http://www.wvdhhr.org/bms/ or call Automated Health at 1-800-449-8466 if you have other questions about this new program.